		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037358

Facility Name: BRIDGEVIEW HEALTH CARE CENTER

Address: 8100 S. HARLEM AVE. (Number) BRIDGEVIEW (City) 60455 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

IDPA ID Number: 36-3780344

Date of Initial License for Current Owners: 10/02/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,405	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,754	1,754	8
9	SNF/PED					9
10	ICF	29,587	13,274		42,861	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,587	13,274	1,754	44,615	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.72%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/02/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 10/02/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 1,754

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	185,925	28,413	8,875	223,213		223,213		223,213			1
2	Food Purchase		227,439		227,439	(38,325)	189,114	(5,198)	183,916			2
3	Housekeeping	119,459	34,623		154,082		154,082	12,177	166,259			3
4	Laundry	69,850	12,412	916	83,178		83,178		83,178			4
5	Heat and Other Utilities			82,772	82,772		82,772	976	83,748			5
6	Maintenance	71,328	30,996	15,197	117,521		117,521	11,399	128,920			6
7	Other (specify):*			15,388	15,388		15,388	650	16,038			7
8	TOTAL General Services	446,562	333,883	123,148	903,593	(38,325)	865,268	20,004	885,272			8
	B. Health Care and Programs											
9	Medical Director			2,100	2,100		2,100		2,100			9
10	Nursing and Medical Records	1,876,138	48,167	39,796	1,964,101		1,964,101	32,488	1,996,589			10
10a	Therapy	5,007		6,862	11,869		11,869	(121)	11,748			10a
11	Activities	193,275	8,994	2,250	204,519		204,519		204,519			11
12	Social Services	15,316		2,001	17,317		17,317		17,317			12
13	Nurse Aide Training			1,456	1,456		1,456		1,456			13
14	Program Transportation											14
15	Other (specify):*							3,128	3,128			15
16	TOTAL Health Care and Programs	2,089,736	57,161	54,465	2,201,362		2,201,362	35,495	2,236,857			16
	C. General Administration											
17	Administrative	63,107		153,509	216,616		216,616	10,247	226,863			17
18	Directors Fees											18
19	Professional Services			63,842	63,842		63,842	(3,178)	60,664			19
20	Dues, Fees, Subscriptions & Promotions			36,723	36,723		36,723	(20,747)	15,976			20
21	Clerical & General Office Expenses	128,399	24,390	221,343	374,132		374,132	(149,238)	224,894			21
22	Employee Benefits & Payroll Taxes			549,135	549,135	38,325	587,460		587,460			22
23	Inservice Training & Education			6,657	6,657		6,657		6,657			23
24	Travel and Seminar							260	260			24
25	Other Admin. Staff Transportation			8,413	8,413		8,413		8,413			25
26	Insurance-Prop.Liab.Malpractice			146,947	146,947		146,947	3,215	150,162			26
27	Other (specify):*			660	660		660	21,189	21,849			27
28	TOTAL General Administration	191,506	24,390	1,187,229	1,403,125	38,325	1,441,450	(138,252)	1,303,198			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,727,804	415,434	1,364,842	4,508,080		4,508,080	(82,753)	4,425,327			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER #0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			40,650	40,650		40,650	123,732	164,382			30
31	Amortization of Pre-Op. & Org.							4,940	4,940			31
32	Interest			31,779	31,779		31,779	399,825	431,604			32
33	Real Estate Taxes			182,886	182,886		182,886	2,840	185,726			33
34	Rent-Facility & Grounds			489,240	489,240		489,240	(489,240)				34
35	Rent-Equipment & Vehicles			13,410	13,410		13,410	8,307	21,717			35
36	Other (specify):*											36
37	**TOTAL Ownership**			757,965	757,965		757,965	50,404	808,369			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		48,058	107,311	155,369		155,369	(2,213)	153,156			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,935	79,935		79,935		79,935			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		48,058	187,246	235,304		235,304	(2,213)	233,091			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,727,804	463,492	2,310,053	5,501,349		5,501,349	(34,562)	5,466,787			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(107,992)	30		9
10	Interest and Other Investment Income	(222)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,562)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,636)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(2,538)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(5,162)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(660)	27		24
25	Fund Raising, Advertising and Promotional	(18,872)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	1,691			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (138,953)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	104,391		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 104,391		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (34,562)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
BRIDGEVIEW HEALTH CARE CENTER
ID# 0037358
Report Period Beginning: 01/01/2002
Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1,691	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	1,691		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,198)	0	0	0	0	0	0	0	0	0	0	(5,198)	2
3	Housekeeping	0	12,177	0	0	0	0	0	0	0	0	0	12,177	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	976	0	0	0	0	0	0	0	0	976	5
6	Maintenance	1,691	0	2,993	6,715	0	0	0	0	0	0	0	11,399	6
7	Other (specify):*	0	0	79	0	571	0	0	0	0	0	0	650	7
8	**TOTAL General Services**	(3,507)	12,177	4,048	6,715	571	0	0	0	0	0	0	20,004	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	32,744	0	(256)	0	0	0	0	0	32,488	10
10a	Therapy	0	0	0	0	0	(121)	0	0	0	0	0	(121)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	3,128	0	0	0	0	0	0	3,128	15
16	**TOTAL Health Care and Programs**	0	0	0	32,744	3,128	(377)	0	0	0	0	0	35,495	16
	C. General Administration													
17	Administrative	0	(153,509)	0	163,756	0	0	0	0	0	0	0	10,247	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,162)	0	1,984	0	0	0	0	0	0	0	0	(3,178)	19
20	Fees, Subscriptions & Promotions	(21,410)	0	663	0	0	0	0	0	0	0	0	(20,747)	20
21	Clerical & General Office Expenses	0	(194,200)	38,922	6,040	0	0	0	0	0	0	0	(149,238)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	260	0	0	0	0	0	0	0	0	260	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,215	0	0	0	0	0	0	0	0	3,215	26
27	Other (specify):*	(660)	0	6,690	0	15,159	0	0	0	0	0	0	21,189	27
28	**TOTAL General Administration**	(27,232)	(347,709)	51,734	169,796	15,159	0	0	0	0	0	0	(138,252)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,739)	(335,532)	55,782	209,255	18,858	(377)	0	0	0	0	0	(82,753)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(107,992)	227,318	4,406	0	0	0	0	0	0	0	0	123,732	30
31	Amortization of Pre-Op. & Org.	0	4,940	0	0	0	0	0	0	0	0	0	4,940	31
32	Interest	(222)	396,171	3,876	0	0	0	0	0	0	0	0	399,825	32
33	Real Estate Taxes	0	0	2,840	0	0	0	0	0	0	0	0	2,840	33
34	Rent-Facility & Grounds	0	(489,240)	0	0	0	0	0	0	0	0	0	(489,240)	34
35	Rent-Equipment & Vehicles	0	0	8,307	0	0	0	0	0	0	0	0	8,307	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(108,214)	139,189	19,429	0	0	0	0	0	0	0	0	50,404	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(2,213)	0	0	0	0	0	(2,213)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(2,213)	0	0	0	0	0	(2,213)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(138,953)	(196,343)	75,211	209,255	18,858	(2,590)	0	0	0	0	0	(34,562)	45

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 153,509	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (153,509)	1
2	V	21	BOOKKEEPING SERVICES	194,200	" "			(194,200)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	489,240	BRIDGEVIEW ASSOCIATES			(489,240)	7
8	V	30	DEPRECIATION		" "		227,318	227,318	8
9	V	31	AMORTIZATION		" "		4,940	4,940	9
10	V	32	INTEREST		" "		396,171	396,171	10
11	V	3	FURNISHING SUPPLIES		" "		12,177	12,177	11
12	V								12
13	V								13
14	Total			$ 836,949			$ 640,606	$ * (196,343)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 976	$ 976	15
16	V	6	REPAIR & MAINT.		" " "	100.00%	2,993	2,993	16
17	V	7	EMP. BEN. - GEN, SERVICES		" " "	100.00%	79	79	17
18	V	19	PROFESSIONAL FEES		" " "	100.00%	1,984	1,984	18
19	V	20	DUES AND SUBSCRIPTION		" " "	100.00%	663	663	19
20	V	21	CLERICAL & GENERAL		" " "	100.00%	38,922	38,922	20
21	V	24	SEMINARS AND TRAVEL		" " "	100.00%	260	260	21
22	V	26	INSURANCE		" " "	100.00%	3,215	3,215	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" " "	100.00%	6,690	6,690	23
24	V	30	DEPRECIATION		" " "	100.00%	4,406	4,406	24
25	V	32	INTEREST		" " "	100.00%	3,876	3,876	25
26	V	33	REAL ESTATE TAXES		" " "	100.00%	2,840	2,840	26
27	V	35	EQUIPMENT RENTAL		" " "	100.00%	8,307	8,307	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 75,211	$ * 75,211	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 6,715	$ 6,715	15
16	V	10	NURSING CMP. - SUE G.		" " "	100.00%	32,744	32,744	16
17	V	17	ADMIN. CMP. - M. MAUER		" " "	100.00%	37,490	37,490	17
18	V	17	ADMIN. CMP. - M. AARON		" " "	100.00%	55,509	55,509	18
19	V	17	ADMIN. CMP. - F. AARON		" " "	100.00%	25,775	25,775	19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%			20
21	V	17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%			21
22	V	17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%	12,533	12,533	22
23	V	17	ADMIN. CMP. - E. CASSON		" " "	100.00%			23
24	V	17	ADMIN. CMP. - S. BOGEN		" " "	100.00%			24
25	V	17	ADMIN. CMP. - S. LEVY		" " "	100.00%	14,526	14,526	25
26	V	17	ADMIN. CMP. - HOWARD ALTER		" " "	100.00%			26
27	V	17	ADMIN. CMP. - NON-OWNER		" " "	100.00%	17,923	17,923	27
28	V	21	CLERICAL. CMP. - S. AARON		" " "	100.00%	6,040	6,040	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 209,255	$ * 209,255	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 571	$ 571	15
16	V	15	EMP. BEN. - SUE G.		" " "	100.00%	3,128	3,128	16
17	V	27	EMP.BEN. - M. MAUER		" " "	100.00%	1,630	1,630	17
18	V	27	EMP. BEN. - M. AARON		" " "	100.00%	2,080	2,080	18
19	V	27	EMP. BEN. - F. AARON		" " "	100.00%	3,808	3,808	19
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%			20
21	V	27	EMP. BEN. - S. KOPLIN		" " "	100.00%			21
22	V	27	EMP. BEN. - D. MAGAFAS		" " "	100.00%	1,738	1,738	22
23	V	27	EMP. BEN. - E. CASSON		" " "	100.00%			23
24	V	27	EMP. BEN. - S. BOGEN		" " "	100.00%			24
25	V	27	EMP. BEN. - S. LEVY		" " "	100.00%	2,097	2,097	25
26	V	27	EMP. BEN. - H. ALTER		" " "	100.00%			26
27	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%	2,672	2,672	27
28	V	27	EMP. BEN. - S. AARON		" " "	100.00%	1,134	1,134	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 18,858	$ * 18,858	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		10a	THERAPY	$ 6,724	DYNAMIC REHAB CONSULTANTS LLC		$ 6,603	$ (121)	15
16	V		19	PROFESSIONAL FEES		" " "				16
17	V		22	EMPLOYEE BENEFITS		" " "				17
18	V		39	ANCILLARY SERVICES	97,410	" " "		95,661	(1,749)	18
19	V									19
20	V									20
21	V		10	MEDICAL SUPPLIES	1,776	LINCOLN MEDICAL SUPPLIES, INC.		1,520	(256)	21
22	V		39	ANCILLARY EXPENSE	3,214	" " "		2,750	(464)	22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 109,124			$ 106,534	$ * (2,590)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER		ADMINISTRATIVE					SALARY	$ 37,490	17-7	1
2	MAURY AARON		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	55,509	17-7	2
3	SHARON AARON		CLERICAL					SALARY	6,040	21-7	3
4	FRED AARON		ADMINISTRATIVE					SALARY	25,775	17-7	4
5	DIANA MAGAFAS		ADMINISTRATIVE					SALARY	12,533	17-7	5
6	DENNIS NEHMER		MAINTENANCE					SALARY	6,715	6-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 144,062		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	441,841	13	$ 9,671	$	44,615	$ 976	1
2	6	REPAIR & MAINT.	" "	441,841	13	29,636	3,380	44,615	2,993	2
3	7	EMP. BEN. - GEN, SERVICES	" "	441,841	13	778		44,615	79	3
4	19	PROFESSIONAL FEES	" "	441,841	13	19,651		44,615	1,984	4
5	20	DUES AND SUBSCRIPTION	" "	441,841	13	6,566		44,615	663	5
6	21	CLERICAL & GENERAL	" "	441,841	13	385,463	300,175	44,615	38,922	6
7	24	SEMINARS AND TRAVEL	" "	441,841	13	2,576		44,615	260	7
8	26	INSURANCE	" "	441,841	13	31,835		44,615	3,215	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	441,841	13	66,254		44,615	6,690	9
10	30	DEPRECIATION	" "	441,841	13	43,634		44,615	4,406	10
11	32	INTEREST	" "	441,841	13	38,384		44,615	3,876	11
12	33	REAL ESTATE TAXES	" "	441,841	13	28,121		44,615	2,840	12
13	35	EQUIPMENT RENTAL	" "	441,841	13	82,269		44,615	8,307	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 744,838	$ 303,555		$ 75,211	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	10	$ 59,032	$ 59,032	5	$ 6,715	1
2	10	NURSING CMP. - SUE G.	" "	40	1	32,744	32,744	40	32,744	2
3	17	ADMIN. CMP. - M. MAUER	" "	40	12	363,103	363,103	4	37,490	3
4	17	ADMIN. CMP. - M. AARON	" "	40	10	487,988	487,988	5	55,509	4
5	17	ADMIN. CMP. - F. AARON	" "	45	6	193,312	193,312	6	25,775	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	37	2	153,497	153,497			6
7	17	ADMIN. CMP. - S. KOPLIN	" "	40	8	71,542	71,542			7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	45	9	87,437	87,437	6	12,533	8
9	17	ADMIN. CMP. - E. CASSON	" "	38	1	31,246	31,246			9
10	17	ADMIN. CMP. - S. BOGEN	" "	45	2	54,060	54,060			10
11	17	ADMIN. CMP. - S. LEVY	" "	45	12	140,632	140,632	5	14,526	11
12	17	ADMIN. CMP. - H. ALTER	" "	40	1	12,000	12,000			12
13	17	ADMIN. CMP. - NON-OWNER	" "	45	12	157,563	157,563	5	17,923	13
14	21	ADMIN. CMP. - S. AARON	" "	40	12	58,502	58,502	4	6,090	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,902,658	$ 1,902,658		$ 209,305	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	10	$ 5,020	$	5	$ 571	1
2	15	EMP. BEN. - SUE G.	" "	40	1	3,128		40	3,128	2
3	27	EMP.BEN. - M. MAUER	" "	40	12	15,782		4	1,630	3
4	27	EMP. BEN. - M. AARON	" "	40	10	18,288		5	2,080	4
5	27	EMP. BEN. - F. AARON	" "	45	6	28,556		6	3,808	5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	37	2	25,672				6
7	27	EMP. BEN. - S. KOPLIN	" "	40	8	22,644				7
8	27	EMP. BEN. - D. MAGAFAS	" "	45	9	12,125		6	1,738	8
9	27	EMP. BEN. - E. CASSON	" "	38	1	3,418				9
10	27	EMP. BEN. - S. BOGEN	" "	45	2	5,010				10
11	27	EMP. BEN. - S. LEVY	" "	45	12	20,299		5	2,097	11
12	27	EMP. BEN. - H. ALTER	" "	40	1	1,296				12
13	27	EMP. BEN. - NON-OWNER	" "	45	12	23,491		5	2,672	13
14	27	EMP. BEN. - S. AARON	" "	40	12	10,982		4	1,134	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 195,711	$		$ 18,858	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS LLC
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION						6,603	2
3	19	PROFESSIONAL FEES	" "							3
4	22	EMPLOYEE BENEFITS	" "							4
5	39	ANCILLARY SERVICES	" "						95,661	5
6										6
7										7
8		LINCOLN MEDICAL SUPPLIES								8
9	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						1,520	9
10	39	ANCILLARY EXPENSE	" "						2,750	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 106,534	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CAMBRIDGE		X	MORTGAGE	$54,580.85	7/01	$ 5,722,000	$ 5,665,001			$ 396,171	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL				570,000		PRIME+	28,676	6
7			X	INSURANCE FINANCING							3,103	7
8	RELATED PARTY	X									3,876	8
9	TOTAL Facility Related				$54,580.85		$ 5,722,000	$ 6,235,001			$ 431,826	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,722,000	$ 6,235,001			$ 431,826	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 183,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 180,886	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,114)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 185,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 182,886	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	171,966	8
	1998	175,735	9
	1999	170,762	10
	2000	177,631	11
	2001	180,886	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible] Office of Health Finance at (217) 782-1600.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIDGEVIEW HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0037358

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-214-061-00000	NURSING HOME	$ 180,886.00	$ 180,886.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 180,886.00	$ 180,886.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,560 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 304,000	1
2					2
3	TOTALS			$ 304,000	3

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	146		1995		$ 5,092,000	$ 227,318	39	$ 130,559	$ (96,759)	$ 1,059,193	4
5											5
6											6
7											7
8					44,793	1,148	35	1,280	132	11,944	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	1,017	32	31.5	32		359	9
10	LEASEHOLD IMPROVEMENTS			1991	2,715	181	15	181		2,029	10
11	LEASEHOLD IMPROVEMENTS			1992	85,574	2,718	31.5	2,718		29,673	11
12	LEASEHOLD IMPROVEMENTS			1993	1,600	51	31.5	51		495	12
13	LEASEHOLD IMPROVEMENTS			1994	8,141	209	39	209		1,780	13
14	1ST FLOOR CENTRAL A/C			1995	1,250	32	39	32		233	14
15	CARPET INSTALL			1995	1,303	33	39	33		238	15
16	RAIL BUMPER			1995	917	24	39	24		169	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM			1996	5,320	136	39	136		901	17
18	PAINTING WORK			1996	8,400	215	39	215		1,371	18
19	WALL COVERING			1996	1,435	37	39	37		233	19
20	FRONT LOBBY/WINDOW,DOOR WORK			1997	2,509	65	39	65		350	20
21	ELEVATOR REPAIR			1998	2,800	72	39	72		351	21
22	CONDENCING UNIT			1999	3,824	98	39	98		358	22
23	DRAPES			1999	5,369	138	39	138		468	23
24	CARPETING AND VINYL FLOORING			1999	8,540	219	39	219		762	24
25	DOOR WORK			1999	10,490	269	39	269		899	25
26	KITCHEN CABINETS			1999	5,832	150	39	150		519	26
27	TILES			2000	8,855	322	27.5	322		780	27
28	ELEVATOR REPAIR			2000	4,240	153	27.5	153		285	28
29	ROD MAIN SEWER			2000	1,100	40	27.5	40		98	29
30	DRAPERIES			2001	2,118	519	7	519		822	30
31	RECEPTION DESK/DOOR			2002	9,534	173	27.5	173		173	31
32	FLOORING / BUMPER GUARDS			2002	11,198	204	27.5	204		204	32
33	WALLPAPER, BORDER, ARTWORK			2002	42,079	656	27.5	656		656	33
34	WIRING,MOTOR			2002	9,224	168	27.5	168		168	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,382,177	$ 235,380		$ 138,753	$ (96,627)	$ 1,115,511	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 222,293	$ 16,451	$ 19,474	$ 3,023	10 YRS	$ 139,193	71
72	Current Year Purchases	39,283	17,285	1,964	(15,321)	10 YRS	1,964	72
73	Fully Depreciated Assets	1,820				10 YRS	1,820	73
74	RELATED PARTY	26,602	1,655	2,296	641	10 YRS	16,570	74
75	TOTALS	$ 289,998	$ 35,391	$ 23,734	$ (11,657)		$ 159,547	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	NURSING, HSKNG,MAIN	1991 DODGE VAN	1991	$ 24,971	$	$	$	4 YEARS	$ 24,971	76
77	RELATED PARTY			5,685	1,603	1,895	292		39,058	77
78										78
79										79
80	TOTALS			$ 30,656	$ 1,603	$ 1,895	$ 292		$ 64,029	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,006,831	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 272,374	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 164,382	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (107,992)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,339,087	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 3,963 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR	2000 GMC JIMMY	$ 489.00	$ 5,383	17
18	PAYROLL DEDUCTION			(3,103)	18
19	TOYOTA		445.00	445	19
20	AMER. EXP		840.00	6,722	20
21	TOTAL		$ 1,774.00	$ 9,447	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 706	$	$ 706
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		750		750
9	TOTALS	$	$ 1,456	$	$ 1,456
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,456			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 42,265	$		$ 42,265	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			965			965	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			58,577			58,577	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				42,963		42,963	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES, RENTALS,LAB Other (specify):	39-2 & 3					10,599		10,599	13
14	TOTAL			$		$ 101,807	$ 53,562		$ 155,369	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER **#** 0037358 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 66,021	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	564,520		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	75,227		7
8	Accounts Receivable (owners or related parties)	165,044		8
9	Other(specify): RE TAX ESCROW	88,595		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 959,407	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	245,382		15
16	Equipment, at Historical Cost	288,367		16
17	Accumulated Depreciation (book methods)	(279,567)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEP	527,500		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 781,682	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,741,089	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 453,476	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	570,000		29
30	Accrued Salaries Payable	295,380		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,564		31
32	Accrued Real Estate Taxes(Sch.IX-B)	185,000		32
33	Accrued Interest Payable	13,539		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,529,959	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,529,959	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 211,130	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,741,089	$	48

***(See instructions.)**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 638,524	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 638,524	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(427,394)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (427,394)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 211,130	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,015,501	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,015,501	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	54,670	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 54,670	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	222	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 222	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNT EARNED	3,562	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,562	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,073,955	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	903,593	31
32	Health Care	2,201,362	32
33	General Administration	1,403,125	33
	B. Capital Expense		
34	Ownership	757,965	34
	C. Ancillary Expense		
35	Special Cost Centers	155,369	35
36	Provider Participation Fee	79,935	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,501,349	40
41	**Income before Income Taxes (line 30 minus line 40)****	(427,394)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (427,394)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,781	2,106	$ 62,856	$ 29.85	1
2	Assistant Director of Nursing	1,733	2,041	56,582	27.72	2
3	Registered Nurses	10,577	12,339	274,714	22.26	3
4	Licensed Practical Nurses	24,942	28,640	550,750	19.23	4
5	Nurse Aides & Orderlies	83,948	93,108	865,445	9.30	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	255	255	5,007	19.64	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,670	1,855	25,097	13.53	9
10	Activity Assistants	14,943	17,864	168,178	9.41	10
11	Social Service Workers	1,170	1,290	15,316	11.87	11
12	Dietician					12
13	Food Service Supervisor	2,629	3,126	41,470	13.27	13
14	Head Cook	2,348	2,578	20,840	8.08	14
15	Cook Helpers/Assistants	16,836	18,056	123,615	6.85	15
16	Dishwashers					16
17	Maintenance Workers	3,834	4,349	71,328	16.40	17
18	Housekeepers	15,056	16,618	119,459	7.19	18
19	Laundry	8,666	9,561	69,850	7.31	19
20	Administrator	2,029	2,357	63,107	26.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,614	9,380	128,399	13.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,437	2,606	42,710	16.39	31
32	Other Health Care(specify)	1,259	1,337	23,081	17.26	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	204,727	229,466	$ 2,727,804 *	$ 11.89	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	245	$ 6,252	1-3	35
36	Medical Director	42	2,100	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	35	1,104	10-3	38
39	Pharmacist Consultant	137	5,480	10-3	39
40	Physical Therapy Consultant	66	3,630	10a-3	40
41	Occupational Therapy Consultant	56	3,094	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	2	138	10a-3	43
44	Activity Consultant	50	2,250	11-3	44
45	Social Service Consultant	40	2,001	12-3	45
46	Other(specify) PSYCHIATRIC	4	180	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	677	$ 26,229		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses	145	3,284	10-3	51
52	Nurse Aides	1,763	29,748	10-3	52
53	TOTAL (lines 50 - 52)	1,908	$ 33,032		53

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTHA PECK	ADMIN	0	$ 63,107
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 63,107

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 153,509
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 153,509

C. Professional Services

Vendor/Payee	Type	Amount
HEALTH DATA SYSTEMS	DATA PROCESSING	$ 4,357
KRUPNICK, BOKOR, KAGDA	ACCOUNTING	20,538
FROST RUTTENBERG	ACCOUNTING	200
FINKEL MARWICK	LEGAL	8,350
SACHNOFF & WEAVER	LEGAL	5,298
LASALLE BANK	LEGAL	450
PERSONNEL PLANNERS	UC CONSULTANT	1,362
DART CHART SYSTEMS	MEDICARE CONSULTANT	19,812
ECONOCARE	PURCHASING CONSLT	2,700
FOX RIVER FOODS	DIETARY CONSULTANT	750
ILL COLLECTION SERVICE	COLLECTIONS	25
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 63,842

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,310
Unemployment Compensation Insurance	15,689
FICA Taxes	208,316
Employee Health Insurance	244,090
Employee Meals	38,325
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	12,730
TOTAL (agree to Schedule V, line 22, col.8)	$ 587,460

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,552
Health Care Worker Background Check	1,126
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	18,872
TRUST/FRANCHISE/CONTRIB/ETC	2,538
LICENSES & PERMITS	2,136
DUES & SUBSCRIPTIONS	7,499
MGMT CO ALLOCATION	663
TRUST/FRANCHISE/CONTRIB/ETC	(2,538)
Less: Public Relations Expense	(0)
Non-allowable advertising	(18,872)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,976

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	0
RELATED PARTY	260
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 260

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATIN	1999	$ 4,058	3	$ 676	$ 1,353	$ 1,353	$ 676	$	$	$	$	$
2	PAINTING/DECORATIN	2000	3,046	3		508	1,015	1,015	508				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 7,104		$ 676	$ 1,861	$ 2,368	$ 1,691	$ 508	$	$	$	$

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL COUNC LONG TERM CARE - 7,906**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,576** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **79,935**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **38,325** Has any meal income been offset against related costs? **NA** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: BRIDGEVIEW HEALTH CARE CENTER #0037358 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,252	
	REPAIRS & MAINTENANCE		2,623	
			0	8,875
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		916	
			0	916
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		28,444	
	ELECTRICITY		38,662	
	WATER		15,666	
	CABLE TV - LOBBY		0	
			0	82,772
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,972	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		1,481	
	ELEVATOR MAINTENANCE & REPAIR		5,844	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,900	
	FIRE SERVICE		0	
			0	
			0	
			0	15,197
7	**OTHER**			
	SCAVENGER		15,388	
	SECURITY SERVICE		0	15,388
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	2,100	2,100

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	33,032	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	5,480	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	180	
	RN CONSULTANT	XVIII B 38-2	1,104	
			0	
			0	39,796
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	3,630	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	3,094	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	138	6,862
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,250	
			0	2,250
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,001	
			0	2,001
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	1,456	1,456

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER #0037358 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	153,509	153,509
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	4,357	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	59,485	
			0	63,842
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	18,872	
	EMPLOYEE WANT ADS	XIX F	4,552	
	CONTRIBUTIONS	VI 20 XIX F	180	
	DUES & SUBSCRIPTIONS	XIX F	7,499	
	LICENSES & PERMITS	XIX F	2,136	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,358	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,126	36,723
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		10,306	
	OUTSIDE CLERICAL SERVICES		194,200	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,837	
	MESSENGER SERVICE		0	
			0	221,343

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	208,316	
	UNEMPLOYMENT COMPENSATION	XIX D	15,689	
	WORKERS COMPENSATION INSURANC	XIX D	68,310	
	HOSPITALIZATION INSURANCE	XIX D	244,090	
	EMPLOYEE BENEFITS - OTHER	XIX D	12,730	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	549,135
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		6,657	6,657
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,413	8,413
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		146,947	146,947
27	**OTHER**			
	BAD DEBTS	VI 24	660	
			0	660

GRAND TOTAL COLUMN 3 OTHER 1,364,842

BRIDGEVIEW HEALTH CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	227,439
LESS SALES TAX	(1,636)
NET FOOD	225,803
TOTAL PATIENT CENSUS	44,615
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	133845
ADD # EMPLOYEE MEALS/DAY	75
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	27375

PATIENT MEALS	133845
ADD EMPLOYEE MEALS	27375
TOTAL MEALS/YEAR	161220
NET FOOD	225803
DIVIDE TOTAL MEALS/YEAR	161220
COST PER MEAL	1.4
TIME EMPLOYEE MEALS	27375
EMPLOYEE MEAL RECLASSIFICATION	38325

BRIDGEVIEW HEALTH CARE CENTER
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S									4,961,450	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	2,201,362	549,135	369,763	83,178	450,652	853,990	79,935	757,965		2,727,804
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	0		1,203			12,207		(13,410)		
CABLE TV			0			0				
CONTRACT NURSING										33,032
INTEREST INCOME							(222)			
NET VENDING COMMISSIONS										
EMPLOYEE PHYSICAL EXAMS		0				0				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						0		0		
O2 INCOME										
BAD DEBTS						(660)	660			
DISCOUNTS LOST							(3,562)			
ANCILLARIES	0							0		
SETTLEMENT INTEREST										
RECLASSED SALARIES	(81,107)	0	0	0	0	81,107	0	0		
HEALTHCARE WORKERS BACKGROUND	0	0	0	0	0		0	0		
PRIOR EXPENSES	0	0	0	0	0		46,648	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	2,120,255	549,135	370,966	83,178	450,652	946,644	123,459	744,555	5,388,844	2,760,836
PER FINANCIAL STATEMENTS	2,120,255	549,135	370,966	83,178	450,652	946,644	123,459	744,555	(427,394)	2,760,836
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									(427,394)	

BRIDGEVIEW HEALTH CARE CENTER - COMPARISONS - 12/31/2002

	ref.	12/31/2002					37,256	DIFF	12/31/2000		
CAPACITY DAYS		53,290			53,290			0	53436		
CENSUS DAYS		44,615			45,019			(404)	46736		
OCCUPANCY %		83.72%			84.48%				87.46%		
SALARIES											
TOTAL General Services	8-1	446,562	8.17%	10.01	426,353	8.02%	9.47	20,209	407,752	19.19%	8.72
Social Services	12-1	15,316	0.28%	0.34	45,860	0.86%	1.02	(30,544)	41,612	1.96%	0.89
TOTAL Health Care and Programs	16-1	2,089,736	38.23%	46.84	1,954,658	36.79%	43.42	135,078	1,824,864	85.89%	39.05
Clerical & General Office Expenses	21-1	128,399	2.35%	2.88	136,838	2.58%	3.04	(8,439)	108,711	5.12%	2.33
TOTAL General Administration	28-1	191,506	3.50%	4.29	200,599	3.78%	4.46	(9,093)	171,015	8.05%	3.66
TOTAL Operation Expense	29-1	2,727,804	49.90%	61.14	2,581,610	48.59%	57.34	146,194	2,403,631	113.13%	51.43
ADJUSTED TOTALS											
Food	2-8	183,916	3.36%	4.12	208,546	3.93%	4.63	(24,630)	197,606	9.30%	4.23
Heat and Other Utilities	5-8	83,748	1.53%	1.88	90,748	1.71%	2.02	(7,000)	83,637	3.94%	1.79
Maintenance	6-8	128,920	2.36%	2.89	107,549	2.02%	2.39	21,371	113,553	5.34%	2.43
TOTAL General Services	8-8	885,272	16.19%	19.84	869,558	16.37%	19.32	15,714	826,201	38.89%	17.68
Administrative	17-8	226,863	4.15%	5.08	177,598	3.34%	3.94	49,265	182,898	8.61%	3.91
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	60,664	1.11%	1.36	52,920	1.00%	1.18	7,744	39,299	1.85%	0.84
Fees, Subscriptions, Promotions	20-8	15,976	0.29%	0.36	12,163	0.23%	0.27	3,813	19,566	0.92%	0.42
License Fee-IDPA	Pg21	0	0.00%	0.00	200	0.00%	0.00	(200)	0	0.00%	0.00
License Fee-Other	Pg21	2,136	0.04%	0.05	5,868	0.11%	0.13	(3,732)	1,940	0.09%	0.04
Clerical & General Office Expenses	21-8	224,894	4.11%	5.04	231,486	4.36%	5.14	(6,592)	194,393	9.15%	4.16
Employee Benefits & Payroll Taxes	22-8	587,460	10.75%	13.17	556,991	10.48%	12.37	30,469	485,762	22.86%	10.39
Payroll Taxes	Pg21	224,005	4.10%	5.02	211,118	3.97%	4.69	12,887	201,379	9.48%	4.31
W/C Insurance	Pg21	68,310	1.25%	1.53	54,779	1.03%	1.22	13,531	55,511	2.61%	1.19
Health Insurance	Pg21	244,090	4.46%	5.47	239,484	4.51%	5.32	4,606	186,108	8.76%	3.98
Inservice Training & Education	23-8	6,657	0.12%	0.15	4,285	0.08%	0.10	2,372	0	0.00%	0.00
Travel and Seminar	24-8	260	0.00%	0.01	920	0.02%	0.02	(660)	5,705	0.27%	0.12
Other Admin. Staff Transportation	25-8	8,413	0.15%	0.19	7,498	0.14%	0.17	915	6,091	0.29%	0.13
Insurance-Prop.Liab.Malpractice	26-8	150,162	2.75%	3.37	116,470	2.19%	2.59	33,692	97,033	4.57%	2.08
Other (specify):*	27-8	21,849	0.40%	0.49	19,256	0.36%	0.43	2,593	12,021	0.57%	0.26
TOTAL General Administration	28-8	1,303,198	23.84%	29.21	1,179,587	22.20%	26.20	123,611	1,042,768	49.08%	22.31
TOTAL Operation Expense	29-8	4,425,327	80.95%	99.19	4,300,651	80.94%	95.53	124,676	3,885,228	182.86%	83.13
Real Estate Taxes	33-3	182,886	3.35%	4.10	184,631	3.48%	4.10	(1,745)	166,762	7.85%	3.57
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	5,466,787	100.00%	**122.53**	5,313,071	100.00%	**118.02**	153,716	2,124,691	100.00%	**45.46**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1738424.4	31.80%	**38.97**	1,627,421	30.63%	**36.15**	111,003	1500173	70.61%	**32.10**

BRIDGEVIEW HEALTH CARE CENTER - DIAGNOSTICS - 12/31/2002

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 1691 from Page 22 and 0 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-400047
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-231724
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.